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LEADERSHIP PAGE

Medicare and Medicaid

An Anniversary to Remember

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President Lyndon B. Johnson signed legislation creating the Medicare and Medicaid programs on July 30, 1965. Although Medicare and Medicaid have not been without their critics—even at the time of enactment—there is no denying the effects of the program on the American health care landscape over the last 50 years.

What started as basic insurance programs for elderly and poor Americans have grown over the last 5 decades to provide access to necessary health care for an even greater number of Americans. Today, because of Medicare, only 2% of the elderly lack health insurance, as compared with 48% in 1962. In addition, the law reduced financial barriers to health care and led to an increase in the percentage of elderly patients seeing physicians by nearly 10% within the first decade of enactment (1).

Like Medicare, Medicaid has also gradually grown from a small health care program, limited to those receiving welfare, into a major provider of health coverage. It is credited for providing necessary prenatal care to low-income pregnant women and ultimately their babies, as well as a large percentage of Americans with disabilities, many of whom require long-term care and services. As a result of Medicaid, low-income children also have access to vaccinations and preventive and primary care, and elderly patients who are unable to afford Medicare premiums or long-term care are not without options.

Indirectly, Medicare can also take some credit for improvements in life expectancy beyond the age of 65 years. In 1965, life expectancy at birth in the United States was 70.2 years. Currently, life expectancy has reached a record high of 78.8 years (2). "Of course, improvements in clinical care and other factors undoubtedly contributed to these health care gains, but before Medicare, many elderly persons might not have had access to the biomedical advances that were developed during that time," wrote David Blumenthal, MD, MPP, and his coauthors in a *New England Journal of Medicine* paper published earlier this year on the origins and evolution of the 2 programs (1).

Blumenthal et al. (1) note that another indirect positive effect of Medicare enactment was the desegregation of hospitals throughout the United States. In compliance with the Civil Rights Act of 1964, the Medicare programs stopped reimbursements to racially segregated health care facilities. The financial hit quickly had hospitals opening their doors to patients regardless of race.

The advent of the new law establishing Medicare and Medicaid was also a pivotal moment in the American College of Cardiology's (ACC's) history. The increasing role of the federal government in health care caused College leaders to recognize the importance of advocacy in helping to ensure that cardiovascular professionals were able to provide the best care to their patients. The ACC in 1965 moved from New York City to Bethesda, Maryland, to be closer to the National Institutes of Health and the nation's capital. Soon after, the College's Government Relations Committee formed, and the ACC assumed an active role with legislators, advocating for physicians and their patients.

So what is next for Medicare and Medicaid? The growth of both programs over the years places them as the nation's largest insurers and as primary contributors to the country's increasing health care costs. More than 90% of older Americans are covered through Medicare alone, and the very likely prospect of accelerated and continued growth in program expenditures is 1 of the more predominant factors driving discussion and debate around reforms, according to Blumenthal et al. (1). Data from 2013

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suggest that the number of Medicare beneficiaries will increase from 52.3 million in 2013 to 81.8 million in 2030 (3). Given this surge in growth and the longer life expectancy, due in part to clinical advances primarily in the realm of disease detection and management (as mentioned previously), costs are on track to outpace growth in the overall economy. Additionally, due to high levels of acuity in some elderly patients, 30% of all Medicare payments are attributed to the 5% of beneficiaries that die each year. Of these costs, one-third occur in the last month of life (4).

Some possible solutions to the cost conundrum already being tested include a movement away from the traditional fee-for-service model toward alternative payment models that reward providers for improved outcomes, lower costs, and greater coordination and integration of services. Value-based purchasing, which arrived on the scene in 2003, aims to provide financial incentives to providers for improvements in quality and cost. Bundled payment models set a fixed price for a "bundle" of services that are typically provided together to treat a specified condition, whereas the blended payment models being used by some private payers and state Medicaid agencies combine shared savings and quality-based bonuses with a fee-for-service payment and a per-patient care management fee for patients served by an advanced primary care practice. Global payment is another concept gaining interest, particularly when it comes to preventive services, in that it would provide advance payment to cover all or most of a patient's care need. Accountable Care Organizations reward groups of providers that assume accountability for the costs and quality of care delivered with shared savings. Development of and involvement with alternative models like these will likely only increase as a result of the passage of the Medicare Access and CHIP Reauthorization Act this past April. This act will provide incentive payments to those who opt to participate in Medicare and private payer alternative payment models beginning in 2018.

There is also a real need to look at the relationship between Medicare and Medicaid and preventive care. For example, screening and early treatment for diseases have proven to be crucial to optimizing physical health and achieving healthy aging. Medicare now covers many preventive services and screenings with no copayments, but there is more that can be done. Managing chronic conditions like diabetes and heart disease is also key. With more than two-thirds of Medicare beneficiaries suffering from chronic conditions, finding ways to prevent and manage these diseases earlier could save money and improve outcomes. Nutrition and physical activity are also important, particularly in the elderly and young children. Studies show that a healthy diet in later years reduces the risk of osteoporosis, hypertension, heart diseases, and certain cancers. Meanwhile, increasing physical activity reduces the risk of many negative health outcomes in older adults, including early death, cardiovascular disease, stroke, diabetes, several forms of cancer, depression, cognitive decline, and falls. Finding opportunities to partner with medical societies, consumer groups, and others around incentives, public/private quality improvement programs, and/or other innovative initiatives could provide positive results both in terms of lowering costs and in improving quality of life for patients.

In these and other areas of Medicare and Medicaid reform, the ACC, thanks to President Johnson, is positioned well to advocate on behalf of its members. Many of us have seen the direct and indirect effects of the Medicare and Medicaid programs on our patients. We can also speak to the challenges of these programs, particularly in today's rapidly changing environment where new technological advances can be read about daily and where patients may not necessarily get and receive care in an office. We have also developed a highly skilled advocacy team consisting of members and staff that are continually fostering relationships with lawmakers at the state and national levels and advocating for necessary research funding, as well as provisions that retain patient access to appropriate, cost-effective care.

It is unlikely that the original authors of the Medicare and Medicaid law expected the programs to evolve to what they are today. Both programs have shown remarkable adaptability and resiliency over the last 50 years. In their paper, Blumenthal et al. (1) caution that, looking ahead, "preserving and strengthening Medicare over the next 50 years will continue to require active, wise, and humane policy development." There will undoubtedly be much debate and change along the way, especially given ongoing Medicaid policy debates, demographic pressures, and other factors, but if history is to be believed, the Medicare and Medicaid programs will continue to grow and adapt over the next 50 years. The ACC will be right there along the way, making sure that what is best for patients and their care team is listened to and acted upon.

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